STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 120158-001**

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 20th day of September 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On March 21, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The case was accepted for review on March 28, 2011.

Because it involved medical issues, the case was assigned to an independent review organization which provided its analysis and recommendations on April 19, 2011.

II. FACTUAL BACKGROUND

The Petitioner receives health care benefits through XXXXX Insurance Agency, which is an underwritten group. Her benefits are defined in the Blue Cross Blue Shield of Michigan (BCBSM) *Comprehensive Health Care Copayment Certificate Series CMM 500* (the certificate). On September 2, 2010, the Petitioner underwent a rhytidectomy of the face and neck, upper lid blepharoplasty, and dermabrasion of the upper lip. These services were provided by Dr. XXXXX at the XXXXX Surgical Center. The charge for this care was $13,320. Dr. XXXXX itemized the surgery in the following "cost analysis" provided to Petitioner:

PROCEDURE	SURGEON'S FEE	SURG. CENTER FEE	ANESTHESIA FEE
Face/neck lift	$6,500.00	2,565.00	750.00
Dermabrasion	875.00	450.00	80.00
Upper lid blepharoplasty	1,200.00	700.00	200.00

BCBSM denied coverage for this treatment, concluding that the care was cosmetic in nature and not medically necessary.

The Petitioner appealed the denial of coverage through BCBSM's internal grievance process. After a managerial-level conference on January 26, 2011, BCBSM did not change its decision and issued a final adverse determination dated February 7, 2011.

III. ISSUE

Did BCBSM properly deny coverage for the Petitioner's September 2, 2010, services as cosmetic surgery under the terms of the certificate?

IV. ANALYSIS

Petitioner's Argument

The Petitioner is seeking reimbursement of $13,320 for corrective facial surgery which she believes was necessary because of disfigurement caused by pesticide poisoning in 2004. The nerve damage caused the right side of her face to droop.

BCBSM has denied all of her medical expenses over the past six years related to her pesticide poisoning. All of her medical treatments were recommended by her non-participating environmental physician. There is no antidote or prescription medicine available to treat pesticide poisoning. The Petitioner has assumed 90% of her medical costs which currently exceed $100,000. She would like BCBSM to pay for this care.

BCBSM's Argument

BCBSM states that under the terms of the certificate, services must be medically necessary to be covered. Services must be clinically appropriate, and considered effective for the member's illness or disease. Services for cosmetic surgery are only payable for corrective purposes and not when primarily used to improve appearance.

The Petitioner indicated that her corrective facial surgery resulted from pesticide poisoning that occurred in 2004. Dr. XXXXX, who performed Petitioner's surgery, met with the Petitioner on July 28, 2010, and indicated in a letter that she was not involved with

Petitioner's prior care and could not address the severity or the result of damage. Nevertheless, Dr. XXXXX stated that Petitioner was a candidate for rhytidectomy of the face and neck. Dr. XXXXX indicated that she could only suspect that at least some of the injuries Petitioner sustained contributed to her facial aging.

In the Petitioner's case, BCBSM argues that her surgical procedures were denied because the documentation does not support medical necessity and were considered cosmetic in nature. The certificate states that services for cosmetic surgery are not payable when services are primarily performed to improve appearance.

Furthermore, BCBSM only pays for facility services when medically necessary and provided by a participating ambulatory surgery facility. The Petitioner's services were rendered at XXXXX which is not a participating facility.

BCBSM maintains that the denial of reimbursement for the Petitioner's surgical services was correct and appropriate, and in accordance with the certificate of coverage.

Commissioner's Review

The certificate, on page 7.13, provides that a service must be medically necessary to be covered. "Medical necessity" is defined in the certificate for both professional services (page 7.13) and hospital services (page 7.14).

Medical necessity for professional services:

> Health care services that a professional provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury disease or its symptoms, and that are:
>
> - In accordance with generally accepted standards of medical practice;
> - Clinically appropriate, in the terms of type, frequency, extent, site and duration, and considered effective for the member's illness, injury or disease and
> - Not primarily for the convenience of the member, professional provider, or other health care provider, and not more costly than an alternative service or sequence or services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that member's illness, injury or disease.

Medical necessity for hospital services:

> Determination by BCBSM that allows for the payment of covered hospital services when all of the following conditions are met:
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> - The covered service is for the treatment, diagnosis or symptoms of an injury, condition or disease.
> - The service, treatment or supply is **appropriate** for the symptoms and is consistent with the diagnosis.
> - In the case of diagnostic testing, the results are essential to and are used in the diagnosis or management of the patient's condition.

In addition, a provision on page 3.31 of the certificate governs when surgery performed at a freestanding ambulatory surgery facility is covered:

> We pay for medically necessary facility services provided by a BCBSM **participating** ambulatory surgery facility.
>
> * * *
>
> **Services That Are Not Payable**
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> - Services by a **nonparticipating** ambulatory surgery facility

The question of whether the Petitioner's September 2, 2010, surgery was medically necessary was presented to an independent medical review organization (IRO) for analysis, as required by section 11(6) of the Patient's Right to Independent Review Act. The IRO reviewer is a physician certified in plastic surgery, who holds an academic appointment and who has been in active practice for more than ten years. The IRO reviewer's report included the following analysis (the full IRO report is being provided to the parties with this Order):

> [T]he member stated that she sustained a nerve injury. However . . . there was no documented examination of facial nerve abnormality included in the documents provided for review. . . . [W]hile rhytidectomy may be suitable as a reconstructive means for facial nerve palsy, the documentation must support that there is some deficit. . . . [T]he only deficit documented is that the member has mild edema and asymmetry, as represented in the photographs presented for review. . . . [T]here are mild to minimal findings to suggest that a rhytidectomy would be appropriate to correct mild edema. . . . [T]here were no records documenting that the member had facial numbness and no evidence to suggest that rhytidectomy would treat this condition. . . . [T]here is evidence of a mild condition of the member's upper lip, which could be consistent with her age. . . . [T]here was insufficient evidence provided for review to demonstrate that this condition was a direct result of her pesticide

> poisoning to support the need for dermabrasion of the upper lip. . . . [T]he operating surgeon was not sure as to the degree that the poisoning caused the member's facial aging. . . .
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> [T]here is evidence that the member's right upper eyelid ptosis and redundant eyelid skin was a change as documented by an evaluation recently after her pesticide poisoning on 11/2/04. . . . [T]he medical record dated 11/2/04 stated that the member had "more ptosis of her right upper lid and brow" in the examination section. . . . [T]hese findings continue to be evident in the photographs dated 1/25/05 and 8/21/07. . . . [T]hese photographs document moderate asymmetry, which is abnormal in appearance. . . . [T]here is adequate documentation from the information provided for review that this is an abnormal condition and that the time course of events supports the poisoning as a cause of this condition. . . . [T]he pesticide poisoning would be considered an accidental injury. . . . [U]pper blepharoplasty is well documented as a procedure for treatment of this type of condition.
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> [The reviewer] determined that the rhytidectomy and dermabrasion and related services that the member underwent on 9/2/10 were not medically necessary for treatment of her condition, but . . . the upper lid blepharoplasty and related services that she underwent on 9/2/10 was medically necessary for treatment of her condition.

The Commissioner is not required in all instances to accept the IRO's recommendation, however the IRO's recommendation is afforded deference by the Commissioner. In a decision to uphold or reverse an adverse determination, the Commissioner must cite "the principal reason or reasons why the Commissioner did not follow the assigned independent review organization's recommendation." MCL 550.1911(16) (b). The IRO reviewer's analysis is based on extensive expertise and professional judgment and the Commissioner can discern no reason why the recommendation should be rejected in the present case. The Commissioner accepts the recommendation of the IRO and finds that the Petitioner's rhytidectomy and dermabrasion were not medically necessary, but her upper lid blepharoplasty was medically necessary. Therefore, the professional service related to her blepharoplasty is a covered benefit under the certificate.

The XXXXX Surgical Center, where the Petitioner had her surgery, does not participate with BCBSM. Since the certificate specifically excludes care provided at nonparticipating surgical centers, the facility charges for her September 2, 2010, surgery are not covered benefits under the certificate.

V. ORDER

Respondent BCBSM's February 7, 2011, final adverse determination is upheld in part and reversed in part. BCBSM shall provide coverage for the professional services (surgeon and anesthesia) for Petitioner's September 2, 2010, blepharoplasty. The amount paid to be determined by BCBSM's normal fee schedule and any applicable deductible or copayment requirements. Coverage is to be provided within 60 days from the date of this Order with proof of compliance submitted to the Commissioner within seven (7) days after coverage has been affected.

BCBSM is not required to cover the professional services related to the Petitioner's rhytidectomy and dermabrasion. It also is not required to cover any of the facility charges related to the Petitioner's September 2, 2010, surgery.

To enforce this Order, the Petitioner may report any complaint regarding implementation to the Office of Financial and Insurance Regulation, Health Plans Division, toll free (877) 999-6442.

Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.